EXECUTIVE SUMMARY

Background and Perspective

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) began an inspection of the District of Columbia (District) Department of Human Services (DHS), Youth Services Administration (YSA) in April 2003. YSA, the District's primary juvenile justice agency, is a large organization and is responsible for a diverse portfolio of service providers and facilities.

The inspection of YSA was conducted in two parts. Part One focused on all operations at the Oak Hill Youth Center (OHYC)[1] in Laurel, Maryland, as well as YSA management and administrative services. A Final Report of Inspection was issued for Part One in March 2004.[2] This report documents Part Two of the inspection, which evaluated the Division of Court and Community Programs (DCCP), formerly known as the Bureau of Court and Community Services (BCCS).

Scope and Methodology

OIG inspections comply with standards established by the President's Council on Integrity and Efficiency, and pay particular attention to the quality of internal control.[3]

The inspection focused on the management and operations of key areas, including compliance with District of Columbia Superior Court mandates, intake and court liaison services, alternative detention services, group and shelter home operations, aftercare and case management services, special residential placement, and community services.

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. Compliance forms with findings and recommendations will be sent to YSA along with this report of inspection. The OIG/I&E Division will coordinate with YSA on verifying compliance with recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

[1] The Oak Hill Youth Center (OHYC) is a secure facility for youths under both short and long-term detention. OHYC has a court-ordered capacity of 188 males and 20 females.

[2] Part One included YSA's Bureau of Administrative Services, Oak Hill Youth Center, Incident Management Investigations, and Operations Division. The Program Development Services of YSA was not inspected and evaluated in either report, as YSA officials stated that this component was not fully functional and had only begun operations in April 2003.

[3] "Internal control" is synonymous with "management control" and is defined by the Government Accountability Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT, Introduction at 4 (Nov. 1999*)*.

FINDINGS AND RECOMMENDATIONS

Key Findings

YSA's group and shelter homes operate without licenses in violation of District laws and regulations. (Page 14) None of the 14 YSA contracted group and shelter homes operating in the District are licensed. According to YSA management, group and shelter homes were established through a pilot program in 1967, at which time there were no licensure requirements. Subsequently, the *Youth Residential Facilities Licensure Act of 1986* was established, but no action was taken to license these facilities. Although YSA management established a licensing unit in April 2004 to assist vendors in meeting licensure requirements, as well as to oversee the group and shelter homes, the team found that facilities still have not been licensed, and YSA has not set a completion date for their licensure. The absence of licenses limits YSA's ability to determine vendor compliance with licensing requirements and to make a standards-based assessment of the overall conditions of the facilities. **Recommendation:** That the A/YSA provide a timetable for all facilities to be licensed, and expedite YSA actions required to ensure that all group and shelter homes adhere to the licensing schedule.

Group and shelter homes operate without valid contracts and written criteria for services, and receive payment for undelivered services. (Page 17) None of the group and shelter homes providing services to DCCP is operating under a current contract awarded through the District's competitive procurement process. YSA has been paying these contractors since 1996 without valid contracts. The absence of contracts and written criteria for service delivery makes it difficult for YSA and District stakeholders to determine efficiency and effectiveness, and whether YSA is receiving what it is paying for. **Recommendations:** (a) That the A/YSA direct the Chief Procurement Officer to develop RFPs to solicit competitive bids among existing and potential vendors for group and shelter homes. (b) That the Office of the Inspector General's Audit Division conduct an audit of all payments for services provided by the group and shelter homes.

Numerous deficiencies documented in group and shelter homes place youth and employees at risk. (Page 19) A physical assessment of the 14 contracted group and shelter homes disclosed that many of the homes lacked general maintenance. DCCP's Licensing, Monitoring, and Quality Assurance Unit (LMQA) inspection reports cited numerous deficiencies; however, in many instances the property owners were not abating the deficiencies. In addition, the team found that group and shelter home monitors were not trained or certified to properly conduct inspections to detect building code violations. Due to inadequate repairs, maintenance, and training, YSA cannot ensure the health and safety of youths and employees in the homes. **Recommendations:** (a) That A/YSA request an inspection of all group and shelter homes by the District of Columbia Office of Risk Management to determine whether there are physical hazards present and to expedite the abatement of deficiencies. (b) That the A/YSA request an inspection by the Department of Consumer and Regulatory Affairs to determine whether there are building code violations present and take the necessary steps to expedite the abatement of any deficiencies found. (c) That the A/YSA provide training and certification to LMQA monitors to ensure the proper monitoring of group and shelter homes. (d) That the

A/YSA require the LMQA Unit to recommend immediate closure of group and shelter homes that have life threatening health and safety issues.

The lack of adequate fire inspections by YSA and FEMS may put group and shelter home residents and employees at risk. (Page 22) The team found that annual fire inspections of group and shelter homes are not conducted by the Fire and Emergency Medical Services, (FEMS), Fire Prevention Bureau, as recommended by The American Correctional Association (ACA). In addition, DCCP does not conduct monthly fire inspections as required, and the quarterly fire inspections that are conducted do not adequately address fire safety requirements of the District's Fire Prevention Code. The lack of annual fire inspections and inadequate quarterly inspections prevents YSA from detecting and correcting fire hazards that may result in serious injury to youths and employees in the event of a fire emergency. **Recommendations:** (a) That the A/YSA immediately request an inspection of all group and shelter homes by the District of Columbia FEMS, Fire Prevention Bureau, in accordance with ACA recommendations. (b) That the A/YSA ensure that FEMS is asked to conduct annual fire inspections of all group and shelter homes, as recommended by ACA. (c) That the A/YSA ensure that LMQA employees conduct monthly fire safety inspections that address the requirements set forth in the District's Fire Prevention Code.

Contract employees do not undergo adequate and updated criminal background checks, and contractors are employing persons with criminal convictions. (Page 23) District regulations require local criminal background checks on contract employees who work in YSA group and shelter homes. A random sampling of employee personnel files disclosed that they did not contain any documentation on background checks. In addition, the team found documentation that contractors were employing persons with criminal convictions. Without adequate background checks on all employees who must routinely interact with youths, YSA may unknowingly hire or have currently employed individuals with a history of violence, abuse, or other criminal behavior that could endanger the youths entrusted to their care and other employees. **Recommendations:** (a) That A/YSA ensure that all candidates for employment and current contract employees with regular contact with youths undergo a MPD criminal background check as required by current policy. (b) That A/YSA develop an internal policy that requires annual updates of criminal background checks for contract employees. (c) That the Director of the Department of Human Services propose legislation to the City Council that would require complete background checks for appropriate contract employees, to include a check of the records of not only MPD but also surrounding law enforcement jurisdictions, an NCIC check, and a review of the Central Registry of Crimes Against Children/Sex Offenders and a Child Protection Registry Check. (d) That the A/YSA ensure that contractors discontinue the practice of employing persons with criminal convictions without approval.

YSA may be underutilizing a D.C.-based, Medicaid reimbursable, residential treatment facility. (Page 27) The team found that an accredited, D.C. Medicaid-approved therapeutic residential treatment facility capable of providing "structured, therapeutic living" to youth with special educational and/or mental health needs may be underutilized by YSA. This facility has a capacity to house 56 youths, yet during the day of the team's tour there were approximately 14 youth living there, and only one had been referred by YSA. **Recommendation:** That the A/YSA designate an internal point of contact at YSA who would be responsible for a review of

all youths currently residing in out-of-state residential facilities to identify those who might be better served by this in-town, therapeutic, Medicaid reimbursable residential facility.

Inaccurate risk assessments, assignments to non-secure community facilities, and ineffective monitoring of youths increase the risk of abscondences from group and shelter homes. (Page 29) Initial risk assessments of some youth offenders placed in community group and shelter homes facilities may not accurately reflect the seriousness of their offenses, their extensive criminal backgrounds, or their potential danger to the community. In addition, the team found that procedures in some group and shelter homes for physical security, and for monitoring youths entering and leaving the facilities each day may be lax and inconsistent. **Recommendations:** (a) That the A/YSA collaborate with the Superior Court Social Services Division on a qualitative review of the intake assessment process. The objectives would be to (1) improve the decision making that leads to the assignment of youths to either secure or non-secure facilities; and (2) lower the risk of dangerous youth offenders absconding back into the community where they might be harmed or harm others. (b) That the A/YSA review security and monitoring practices in all group and shelter homes and ensure that day-to-day operations serve to minimize the risk of abscondences, while meeting the requirements to provide residential care, treatment, and services for the youths. (c) That the A/YSA review the feasibility of automatically placing youths who abscond from a group or shelter home into more secure facilities once they have been apprehended.

DCCP's Absconder Locator Component (ALC) has not been successful in locating and returning youth to YSA's custody in a timely manner. (Page 34) The team found that 223 youths have absconded from group and shelter homes since June 2001. The team documented that 68 youths who are considered to be in YSA's custody are still in absconder status, and 23 of the 68 have been missing for over 2 years. The team found that a lack of clear policies and procedures, field investigations, photographs of youths, and limited coordination between YSA and MPD have contributed to the low success rate in locating and returning youths to YSA's custody. **Recommendations:** (a) That the A/YSA take immediate steps to ensure that all youths are photographed, and that photos are placed in each case file. (b) That the A/YSA immediately put into place interim procedures and performance standards for the ALC until a permanent document is approved. We recommend that the procedures emphasize the need for prompt notification of MPD when custody orders have been signed, the transmittal of key identifying information, the conduct of field investigations in all cases, and diligence in efforts to locate absconders as soon as possible. (c) That the A/YSA seek to expedite approval among all concerned agencies of the draft MOU on abscondence policies and procedures so that ALC and MPD roles and responsibilities regarding locating and apprehending absconders can be clarified and implemented quickly.

DCCP lacks written policies and procedures for key operations. (Page 40) The team found that DCCP lacks written policies and procedures for key operations, including: administration; group and shelter home operations; aftercare services; and alternative detention services. The lack of written policies and procedures may contribute to inconsistency in daily operations, and makes it difficult for YSA officials and District stakeholders to determine if proper services and treatment are being provided to youths served by DCCP.

Recommendation: That the A/YSA expedite the process of establishing written policies and procedures for all key functions within DCCP.

DCCP apparently lacks updated position descriptions and performance standards for all employees. (Page 41) DCCP did not provide requested written position descriptions and performance standards for all job categories, including the positions of Deputy Administrator, Assistant Deputy Administrator for Diagnostic and Committed Services, and Assistant Deputy Administrator for Intake and Detention Services. Employees without position descriptions may not have clearly defined tasks, and the lack of performance standards does not allow managers, employees, and District stakeholders to accurately access whether employees are adequately performing their duties. **Recommendation:** That the A/YSA establish written position descriptions and performance standards for all DCCP employees.

Licensing, Monitoring and Quality Assurance Unit

Some group and shelter home employees are not undergoing required pre-employment illegal drug and alcohol testing. (Page 44) The team conducted a random sampling of group and shelter home employee personnel records to verify compliance with required pre-employment drug and alcohol testing. The team found no documentation indicating that pre-employment tests for drugs and alcohol had been conducted. The lack of pre-employment testing for illegal drug and alcohol use by contract employees could place YSA youth and the District government at risk if individuals who have problems with substance abuse are hired. **Recommendations:** (a) That the A/YSA ensure that test for illegal drugs and alcohol are conducted on all contract employees. (b) That the A/YSA ensure that test results are maintained in each contract employee's personnel records.

Some group and shelter home employees are not undergoing pre-employment and follow-up physical examinations as required by District regulations. (Page 45) The team reviewed a random sample of 25 contract employee personnel files and found that a significant number of files had no documentation that pre-employment physical examinations were conducted. In addition, the team found that contract employees are not undergoing follow-up physical examinations every 24 months as required. The failure of contract employees who work closely with youths to undergo pre-employment and follow-up examinations could expose youths to a communicable disease, as well as impair employees' ability to provide care. **Recommendations:** (a) That the A/YSA ensure that all contract employees undergo required physical examinations. (b) That the A/YSA ensure that all contract employees undergo a follow-up examination every 24 months.

Community-based programs may be underutilized. (Page 46) The team reviewed utilization reports provided by a YSA "fee-for-service" community-based provider and found thousands of unused hours even though YSA had budgeted for these services. YSA's failure to adequately use these services may have denied many YSA youths the benefits of counseling, mentoring, and after school tutoring programs. **Recommendation:** That the A/YSA take appropriate action to ensure that DCCP Case Managers and their supervisors make full use of budgeted, community-based programs to provide home-based counseling, mentoring, and after-school enrichment programs to more YSA youths.

Pre-Trial and Community-Based Services

YSA's electronic monitoring unit does not effectively monitor youths in the evenings and on weekends. (Page 51) DCCP does not have adequate staff to properly respond to electronic monitoring alerts during evening and weekend hours. Its inability to continually monitor and promptly respond to electronic violation alerts severely weakens the effectiveness of the program. **Recommendation:** That the A/YSA assign or hire the personnel necessary to respond promptly to all after-hours and weekend electronic monitoring violations.

Tours-of-duty for case managers in the Alternative Detention Division do not adequately cover periods when youths are at higher risk for delinquency. (Page 52) Nearly all ADD case managers complete their workday by 6 p.m., and none work weekend hours. In other jurisdictions, alternative detention case managers routinely meet with youths and their families during evenings and weekends when youths are at a higher risk for delinquency. **Recommendation:** That the chief of the ADD meet with YSA's human resources specialist and the ADD case managers to discuss the feasibility of revising tours-of-duty of current case managers to include some evening and weekend hours or hiring employees specifically to work evenings and weekends.

Alternative Detention Division case managers are often impeded by delayed court orders and a lack of vital case information. (Page 54) ADD case managers cited lengthy delays in getting court-ordered referrals that detail the parameters of home release for pre-trial youths, as well delays in getting vital case information, such as signed parental consent forms and social histories. **Recommendations:** (a) That the A/YSA meet with representatives from the D.C. Superior Court Social Services Division to (1) determine why ADD case managers do not receive all of the court orders and information they require on a timely basis, and (2) devise procedures to improve the flow of information between the court and YSA. (b) That the Supervisor of DCCP's Court Liaison unit take action to ensure that Court Liaison representatives obtain the requisite signatures on all information release forms and youth participation agreements.

Alternative Detention Division case managers feel that current fieldwork practices are unsafe. (Page 56) Case managers routinely encounter parents who resist their intervention, alcohol- and drug-influenced family members, and dangerous neighborhoods. However, the ADD does not have written policies and procedures that cover field safety, and it is routine practice for case managers to make unaccompanied home visits. The lack of recommended, well-conceived safety policies and procedures puts the safety of youths and case managers at risk. **Recommendations:** (a) That the A/YSA convene a meeting with all personnel who conduct field work to discuss ways in which the Division can improve safety and effectiveness while working with families in their homes, transporting youths, etc. (b) That the A/YSA work with the Washington, D.C.-based National Association of Social Workers and the Metropolitan Police Department to (1) develop policies and procedures that address case manager safety and (2) identify applicable training opportunities that focus on areas such as non-violent self defense de-escalation techniques. (c) That the A/YSA assess the feasibility of formally implementing a "partner system" in order to reduce the number of instances when case managers must visit client homes alone.

The Central Processing Unit (CPU) does not have a TB infection control program for employees as recommended by the Centers for Disease Control. (Page 58) CPU employees expressed concern about exposure to youths in their custody who may test positive for TB. They stated they have not received any type of training, annual testing, or information that would help them to better understand the risks, if any, posed by exposure to the TB bacterium. **Recommendations:** (a) That the A/YSA organize information sessions during which all CPU employees, as well as any other front-line YSA employees who wish to participate, receive a fundamental understanding of TB transmission, the frequency with which TB appears in juvenile facilities, and the risks, if any, posed by exposure. (b) That the A/YSA implement a baseline skin-testing program for all front-line YSA corrections employees.

The Alternative Detention Division lacks an employment, vocational, and training counselor. (Page 59) DCCP does not have an employee dedicated to the task of identifying and coordinating employment, vocational, and training opportunities for YSA youths. **Recommendation:** That the A/YSA approve the hiring of a vocation and employment coordinator who would (1) focus exclusively on identifying opportunities and maintaining relationships with public and private sector training programs and employers, and (2) assist ADD case managers with matching youths to employment and training opportunities.